K-H3-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

05407

Reg. Dist. No. 338

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wic

City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Adshead William Custer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1945

8. AGE: Years 1 | Months 11 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace Sharptown Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Walter Adshead

13. Birthplace Md

MOTHER 14. Maiden name Ida O. Riggin

15. Birthplace Md

16. Informant Walter Adshead

Address Sharptown

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-17-1947 (month) (day) (year)

Cemetery or crematory Taylor

Location Sharptown

18. Funeral director Draper-Bros

Address Sharptown Md

19. 6/16/1947 Harriet L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 12 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to 6-15-47 19...

and that I last saw h... alive on 6-15-47 19...

Immediate cause of death	DURATION
Tuberculous meningitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William H. Fitch Jr. M. D. or other

Address Salisbury, Md Date signed 6-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

05408

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred: 1110 E. Church St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 1110 E. Church St. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sallie Maude Buttingham
3.(b) Social Security Number: ✓

4. Sex: Female ✓
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Mitchell Buttingham ✓
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept. 13, 1873

8. AGE: Years 73 | Months 8 | Days 16 | If less than one day ..... hrs. ..... min.
8. Birthplace: Shenneville, Wicomico, Md. (Town, county, and state)
10. Usual occupation: At Home ✓
11. Industry or business:
FATHER 12. Name: Elijah James Truitt
13. Birthplace: Wicomico Co., Md.
MOTHER 14. Maiden name: Mary Ann Hitchens
15. Birthplace: Wicomico Co., Md.
16. Informant: Mrs. Maude B. Mayes
Address 1110 E. Church St. Salisbury, Md.
17. Burial (Buriel, cremation, or removal. Which?) Date thereof 6/17/47 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md
18. Funeral director: R. Hill & Wilson Co.
Address: Salisbury, Md.
19. 6/18, 1947 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9, 1947, at 12:45 noon M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to June 1947 and that I last saw her alive on June 9 1947
Immediate cause of death: a. Uremia — DURATION
Due to: Arteriosclerotic C-V-D
Due to: Disease
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: H. M. Grier Jr. M. D. or other
Address: Salisbury Md. Date signed 6/17/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05409

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: R.D. #2.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For children born in infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Benjamin Brown

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Sarah Brown
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): May 15 1853
8. AGE: Years: 94 Months: 1 Days: 8 If less than one day: hrs. min.
9. Birthplace: Pittsville Maryland (Town, county, and state)
10. Usual occupation: retired Farmer
11. Industry or business:
FATHER 12. Name: William Brown
13. Birthplace: Pittsville Maryland
MOTHER 14. Maiden name: Sarah Warrington
15. Birthplace: Sussex Co. Delaware
16. Informant: Mr Wilbur E. Brown
Address: R.D. #2 Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25-47 (month) (day) (year)
Cemetery or crematory: County Cem.
Location: R.D. Salisbury Maryland
18. Funeral director: Holloway-Walter R. Willing
Address: Salisbury Maryland
19. 6/26/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1947, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Paralysis Cerebral 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Carcinoma of Prostate	several months
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elmer T. Hearn M.D.
Deputy Coroner
M. D. or Other
Address: Salisbury Md. Date signed: 6-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

Ans. 105410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME: Mary Edna Brown

3.(b) Social Security Number:

4. Sex: F.
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Levin Brown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 5, 1845
8. AGE: Years: 102 Months: 1 Days: 1 If less than one day: ..... hrs. ..... min.
9. Birthplace: Marsela, Wicomico, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: James Dashiell
FATHER 13. Birthplace: Marsela Md.
MOTHER 14. Maiden name: Margaret ?
MOTHER 15. Birthplace:
16. Informant: Mr. Monroe
Address: Quantico Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/18/47 (month) (day) (year)
Cemetery or crematory: Quantico Md.
Location: Quantico Cem.
18. Funeral director: David L. Wallick
Address: Nelson Md.
19. 6/17/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/15/47, at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to June 15 1947 and that I last saw h.. alive on June 11 1947

Immediate cause of death: Chronic nephritis — DURATION: 2 yrs.
Due to: — DURATION:
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Cramer M.D.
M. D. or other
Address: Salisbury Md. Date signed: June 17

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1647

CERTIFICATE OF DEATH

05411

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Sharptown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Sharptown (Rural Riverton)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel A Brown

3.(b) Social Security Number 222-01-9345

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Jessie Brown

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21st 1912

8. AGE: Years	Months	Days	If less than one day
35	4	13	hrs. min.

9. Birthplace Sussex County, Delaware (Town, county, and state)

10. Usual occupation Store Keeper

11. Industry or business Lewis Store

FATHER 12. Name Charles D. Brown

13. Birthplace Wicomico Co. Md.

MOTHER 14. Maiden name Ruth Hovington

15. Birthplace Sussex Co. Del.

16. Informant Jessie Brown

Address 201-E. 13th St. Wilmington

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 1947 (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location San Domingo, Md.

18. Funeral director J. J. Franklin & Son

Address Federalsburg, Md.

19. 6-13 1947 (Date rec'd by registrar) Walter G. Mears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1947 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to June 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning	Sudden
Due to Suicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of June 9th 1947

Where did injury occur? Riverton, Wicomico Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Pocomoke River

Means of injury Drowning Injured at work? No

23. SIGNATURE Chas. F. Fisher M.D.

M. D. or other

Address Deputy Coroner Salisbury, Md. Date signed 6-11-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05412

Reg. Dist. No. 337.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Wicomico

City or town Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Cornelius Burke, Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Widower

6.(b) Name of husband or wife Nellie Burke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 24, 1888

8. AGE: Years	Months	Days	If less than one day
59	1	8	..... hrs. ..... min.

9. Birthplace Polks Road, Somerset, Md (Town, county, and state)

10. Usual occupation General Laborer

11. Industry or business

FATHER 12. Name William H. Burke

13. Birthplace unborn

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Edward C. Burke, Jr.

Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/4/47 (month) (day) (year)

Cemetery or crematory Cemetery

Location Tyaskin, Md.

18. Funeral director C. S. Messicks

Address Bivalve, Md.

19. June 4 1947 R. Woolford Potter

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947, at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7 May 1947, to 2 June 1947.

and that I last saw him alive on 2 June 1947.

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease with Cardiac Failure	2 wks.
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward H. Saunders M.D. M. D. or other

Address Crisfield Md. Date signed 3 June 47.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

05413

CERTIFICATE OF DEATH

Reg. Dist. No. 733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 months
Hospital, institution, or street address where death occurred: 339 New York ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 339, New York ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George C. Carter

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Mary E. Carter
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Dec. 10-1865

8. AGE: Years 81 | Months 5 | Days 27 | If less than one day ... hrs. ... min.

9. Birthplace: Appomattox Virginia (Town, county, and state)
10. Usual occupation: Retired Farm Manager
11. Industry or business:

FATHER
12. Name: George Carter
13. Birthplace: Oatland, Va.

MOTHER
14. Maiden name: Katherine Powell
15. Birthplace: Loudoun Co. Va.

16. Informant: Mr. Robert B. Carter
Address: 339 New York ave. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 10-47 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Leesburg Virginia

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. (Date rec'd by registrar) 6/7 19 47 Harriet L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7th 1947 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to June 7 1947 and that I last saw h[illegible] alive on June 6 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage.	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lucy A Leslie M. D. or other
Address: Salisbury Md Date signed 6-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05414

1310

Reg. Diat. No. 335

1. PLACE OF DEATH:
County: Queenes
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md County: Wic
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward H Cooper

3.(b) Social Security Number:

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Myrtle R. Cooper
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): July 14 1876

8. AGE: Years: 70 Months: 11 Days: 14. If less than one day: hrs. min.

9. Birthplace: Sharptown Wic Md
(Town, county, and state)
10. Usual occupation: General work
11. Industry or business:
FATHER 12. Name: William H. Cooper
13. Birthplace: Md
MOTHER 14. Maiden name: Mariah V Burford
15. Birthplace: Md
16. Informant: Myrtle Cooper
Address: Sharptown
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-29-1947 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Sharptown
18. Funeral director: Graham or Bros
Address: Sharptown
19. 6-28 1947 (Date rec'd by registrar) Walter F Mears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/27 19 47 at 5-10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/25 19 47 to 6/27 19 47 and that I last saw h[illegible] alive on 6/25 19 47

Immediate cause of death	DURATION
(a) Uremia	
Due to: (b) Nephrosclerosis	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C M Moyer M. D. or other
Address: Laurel Del. Date signed: 6/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

610

610

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

05415

CERTIFICATE OF DEATH

Reg. Dist. No. 33a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Wicomico,
City or town Mardella, Rural, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland. County Wicomico,
City or town Mardella, Rural, (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary B. Deshield,
3. (b) Social Security Number 219-07-6747

4. Sex Female, 5. Color or race Colored, 6.(a) Single, married, widowed, or divorced Widowed,
6.(b) Name of husband or wife Jacob S. Deshield,
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) October 25th, 1896

8. AGE:	Years	Months	Days	If less than one day
	50	7	22	hrs. min.

9. Birthplace Wicomico County, Maryland. (Town, county, and state)
10. Usual occupation Day labor,
11. Industry or business House-work & field work,
FATHER 12. Name Levin J. Thomas,
13. Birthplace Sussex County, Delaware.
MOTHER 14. Maiden name Caroline Hall,
15. Birthplace Wicomico County, Md.
16. Informant Mrs Mary Lawrence,
Address Quantico, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20" 1947 (month) (day) (year)
Cemetery or crematory Mardella Cemetery,
Location Mardella, Maryland.
18. Funeral director J. J. Framptom & Son,
Address Federalsburg, Maryland.
19. 6/20/47 (Date rec'd by registrar) W H Roberts Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th, 1947, at 4 15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...; and that I last saw h... alive on ... 19... [written across: medical examiner certificate]

Immediate cause of death Cerebral Hemorrhage — DURATION 1 hr
Due to
Due to
Other conditions None (Include pregnancy within 3 months of death)
Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: [illegible]
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J A Kadenmoker MD. Deputy Med Examiner M. D. or other
Address Salisbury Md Date signed 6/18/47

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

05416

CERTIFICATE OF DEATH

Reg. Dist. No. 335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wic
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Willard T. English

3.(b) Social Security Number: 220-07-2221

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Annie E. English
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): Sept 28, 1871

8. AGE: Years: 75 Months: 8 Days: 15 If less than one day: hrs. min.

9. Birthplace: Bethel Sussex Del
(Town, county, and state)
10. Usual occupation: Labor
11. Industry or business:
FATHER 12. Name: Thomas English
13. Birthplace: Del.
MOTHER 14. Maiden name: Eliza Massey
15. Birthplace: Del
16. Informant: Annie E. Ellis
Address: Sharptown
17. Burial (Burial, cremation, or removal which?) Date thereof: 6 15 1947 (month) (day) (year)
Cemetery or crematory: Church Cemetery
Location: Mardela
18. Funeral director: Graveyor Bros
Address: Sharptown Md

19. June 14 1947 Walter G Heam
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1947 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945, to June 13 1947
and that I last saw h... alive on June 13 1947

Immediate cause of death: Bronchial Ectasis. — DURATION: 05 Years
Bronchiectasis
Due to:
Due to:
Other conditions: Chronic Valvular Disease — 2 Years
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other
Address: Sharptown Md Date signed: 6/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05417

61

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

R 7 10 # 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 418 East St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Olivia Alice Esham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Jno T. Esham

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1875

8. AGE: Years 71 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Wicomico County, Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Methias Tingle

13. Birthplace Wicomico County, Md.

MOTHER 14. Maiden name Ann Sophia Watson

15. Birthplace Wicomico County, Md

16. Informant Mrs Lillie Otwell

Address Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/26/47 (month) (day) (year)

Cemetery or crematory Nelsons

Location Delmar, Del R 7 #3

18. Funeral director W. S. Ingram & Co

Address Delmar, Del

19. June 26, 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at 11:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946, to June 24 1947

and that I last saw h... alive on June 24 1947

Immediate cause of death	DURATION
Uremic Coma	4 days
Due to Chronic Nephritis	6 yrs
Due to Diabetes Mellitis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. H. Lynch M. D. or other

Address Delmar Del Date signed June 26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

05418

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 1 day

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Gordon

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Farlow Jester, Phillip

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 5-20-1930

8. AGE:

Years	Months	Days	If less than one day
17	0	13	..... hrs. ..... min.

9. Birthplace: Salisbury, Wicomico Co., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Drug Store

FATHER

12. Name: Norman Farlow

13. Birthplace: Salisbury, Md.

MOTHER

14. Maiden name: Pauline Jester

15. Birthplace: Salisbury, Md.

16. Informant: Charles Jester

Address: 104 Gordon St. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-47 (month) (day) (year)

Cemetery or crematory: Green Acres

Location: Salisbury Maryland

18. Funeral director: James T. Stewart

Address: 402 E. Church St. Sals. Md.

19. 6/9 1947 Harris E. Johnson Deal Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1947, at 12 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 3 1947

and that I last saw h. alive on June 3 1947

Immediate cause of death: Drowning

DURATION: Instant death

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of —

Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Johnsons Lake

Means of injury Became exhausted while swimming Injured at work? No

23. SIGNATURE: Jos Rodenbaugh MD

M. D. or other

Address: Salisbury Md. Date signed 6/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Long

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

98

05419

CERTIFICATE OF DEATH

Reg. Diat. No. 999

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fisher Samuel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Widower

6.(b) Name of husband or wife Georgeanna Fisher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66	3	20	..... hrs. ..... min.

9. Birthplace Snow Hill, Md (Town, county, and state)

10. Usual occupation Farm Labor

11. Industry or business

FATHER 12. Name Geo. Fisher

13. Birthplace Snow Hill Md

MOTHER 14. Maiden name ?

15. Birthplace ?

16. Informant Martin Hammond

Address Mt Herman Rd & Cary Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/29/47 (month) (day) (year)

Cemetery or crematory Cool Spring Church Cem.

Location Fiddletree, Worcester Co. Md.

18. Funeral director Howard A. Gill

Address Pocomoke City, Md

19. 6/28 19 47 Received by Essie L. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 47 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 47 to June 25 19 47 and that I last saw h. alive on June 25 19 47

	DURATION
Immediate cause of death Cardiac & respiratory failure	5 minutes
Due to arteriosclerosis, generalized.	5 years
Due to	
Other conditions Ruptured duodenum 10 minutes before 5 a.m.	

(Include pregnancy within 3 months of death)

Major findings of operation Exploration 3rd toe, right

Date of op. June 25, 1947

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William B. Long M. D. or other

Address 504 W. Division St. Salisbury, Md. Date signed June 25, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05420

Reg. Diat. No. 3223

1. PLACE OF DEATH:

County: Sussex

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 3 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Del. County: Sussex

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Elva E Fletcher Sr.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertie Fletcher

6.(c) If alive, give age: 21+ years

7. Birth date of deceased (mo., day, yr.): May 24 1882

8. AGE: Years	Months	Days	If less than one day
64	1	0	hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: ✓

FATHER — 12. Name: Lemuel Fletcher

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Lavenia Covington

MOTHER — 15. Birthplace: Delaware

16. Informant: Bessie Ellis

Address: Laurel Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28. 47 (month) (day) (year)

Cemetery or crematory: Odd Fellows Cemetery

Location: Laurel Del

18. Funeral director: Harvey Williams

Address: Federalsburg Md.

19. 6/27/47 (Date rec'd by registrar) Bessie Ellis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1947 at 11½ P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 1945 to June 24 1947

and that I last saw him alive on June 24 1947

Immediate cause of death: Coronary infarction — DURATION: 6 mo.

Left ventricular failure — 2 mo.

Pulmonary edema — 1 day

Due to: Hypertensive heart disease ?

Hypertension, essential ?

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. V. Sohler M.D. M. D. or other

Address: Delmar, Del Date signed: 6-26-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

05421

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred: 113 Walnut Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No.: 113 Walnut Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: CARRIE LEE FORMAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Harry Forman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 26, 1862

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	8	9		

9. Birthplace: Queen Anne Co., Maryland (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Robert Perry

FATHER — 13. Birthplace: Queen Anne Co., Maryland

MOTHER — 14. Maiden name: Mary C. Bryan

MOTHER — 15. Birthplace: Queen Anne Co., Maryland

16. Informant: Mrs. P. E. Burroughs

Address: Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/6/47 (month) (day) (year)

Cemetery or crematory: Centerville

Location: Centerville, Maryland

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland

19. 6/6 (Date rec'd by registrar) 1947 Harriet S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4th 1947, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/29 1947, to 6/4 1947, and that I last saw h... alive on 6/4 1947.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. T. Fisher M.D. M. D. or other

Address: Salisbury Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

05422

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or Institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar Route #2
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Gaines, Annie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	married

6.(b) Name of husband or wife: Randolph Gaines

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): July 4th - 1897

8. AGE:

Years	Months	Days	If less than one day
49	11	15	hrs. min.

9. Birthplace: Dorchester County, Md.
(Town, county, and state)

10. Usual occupation: House-work

11. Industry or business: Own home

FATHER

12. Name: George Steward

13. Birthplace: Dorchester County, Md.

MOTHER

14. Maiden name: Anna Rebecca Dodkins

15. Birthplace: Dorchester County, Md.

16. Informant: Randolph A. Gaines

Address: Delmar, Del. R.F.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23rd 1947 (month) (day) (year)

Cemetery or crematory: Mt. Nebo Cemetery

Location: Sharptown, Md. (Rural)

18. Funeral director: J. J. Examptom & Son

Address: Federalsburg, Md.

19. 6/20/47 (Date rec'd by registrar) Isaac L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1947 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 19 1947 and that I last saw h[illegible] alive on June 19 1947

Immediate cause of death	DURATION
Subarachnoid Hemorrhage	Symptoms 2 weeks
Due to	
Due to	
Other conditions: Hemorrhage Left frontal lobe	Symptoms 3 days
Bronchopneumonia	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: David J. Gilmore M.D.
M. D. or other

Address: 201 N. Dennis Date signed June 19 1947

Salisbury

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05423

Reg. Dist. No. 338

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Walnut Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GRAHAM GUNBY SR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Virginia Gordy Gunby

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 18, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	9	hrs. min.

9. Birthplace: Salisbury, Wicomico Co., Maryland (Town, county, and state)

10. Usual occupation: Hardware

11. Industry or business:

FATHER

12. Name: L.W. Gunby

13. Birthplace: Wicomico Co., Maryland

MOTHER

14. Maiden name: Frances G. Graham

15. Birthplace: Wicomico Co., Maryland

18. Informant: Graham Gunby Jr.

Address: 311 Long Ave., Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/30/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Maryland

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland

19. 6/28, 1947 (Date received by registrar) Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1947, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 27 1947 and that I last saw him alive on 6/27/ 1947

	DURATION
Immediate cause of death: Pulmonary Embolism	
Due to: Thrombosis of external iliac vein	
Due to: Hemicorrhaphy	
Other conditions: Herniorrhaphy	
Subacute Pancreatitis (Include pregnancy within 3 months of death)	

Major findings of operations: Bilateral direct inguinal hernia Date of op.

Autopsy results: Record

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred R. Grayson M.D. M. D. or other

Address: Salisbury, Md. Date signed: 6/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

05424

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
511 Camden Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 Camden Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CLARA B. HEARN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward L. Hearn
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): January 16, 1877

8. AGE: Years	Months	Days	If less than one day
70	5	10	....hrs. ....min.

9. Birthplace: Sussex Co., Delaware
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: James Rodney Lecates
13. Birthplace: Sussex Co., Delaware

MOTHER
14. Maiden name: Eliza Jane Vincent
15. Birthplace: Sussex Co., Delaware

16. Informant: Edward L. Hearn
Address: 511 Camden Ave., Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/28/47 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Maryland

16. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Maryland

19. 6/28 (Date rec'd by registrar) 1947 H. T. Harris Hill Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 1947, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1935 to June 26 1947
and that I last saw her alive on June 26 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to: Hypertension	15 yrs.
Due to:	
Other conditions: Enlarged Heart - Valvular Heart Disease. Chronic Nephritis	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elmer R Mann M. D. or other
Address: Salisbury Md Date signed: 6/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05425

Reg. Diat. No. 333

1. PLACE OF DEATH:

County WICOMICO CO.

City or town SALISBURY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 DAYS

Hospital, institution, or street address where death occurred:

PENINSULA GENERAL HOSPITAL

How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County SOMMERSET CO.

City or town PRINCESS ANNE, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. OAK STREET

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME JEROME HICKMON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ELLA DAISY MUIR

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) JANUARY 24, 1896

8. AGE: Years	Months	Days	If less than one day
51	4	11	...hrs. ...min.

9. Birthplace CRISFIELD MARYLAND (Town, county, and state)

10. Usual occupation CARPENTER

11. Industry or business —

FATHER 12. Name ISAAC WILLIAM HICKMON

13. Birthplace CRISFIELD, MARYLAND

MOTHER 14. Maiden name CHARLOTTE PHOEBUS

15. Birthplace CRISFIELD MARYLAND

16. Informant ELLA DAISY HICKMON

Address PRINCESS ANNE, MARYLAND

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 8 1947 (month) (day) (year)

Cemetery or crematory ST. ANDREW'S EPISCOPAL

Location PRINCESS ANNE MARYLAND

18. Funeral director MEDFORD L. WATSON JR.

Address SEAFORD, DELAWARE

19. 6/6 1947 Raquel D. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947 at 8:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1947 to June 5 1947 and that I last saw h... alive on June 5 1947

Immediate cause of death Cerebral Hemorrhage (right lateral ventricle) — DURATION 12 hours

Due to Cerebral Thrombosis (Diffuse encephalomalecia) — DURATION Symptoms 1 month

Due to Arteriosclerosis, cerebral — DURATION Symptoms 1 month

Other conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE David J. Gilmore M.D.

M. D. or other

Address 201 N. Division St. Salisbury, Md. Date signed June 6 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05426

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: R.D. # 2,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mariah Frances Holloway

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Sylvester R. Holloway
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Aug. 19 - 1867
8. AGE: Years 80 Months 10 Days 8 If less than one day: hrs. min
9. Birthplace: R.D. Quantico Maryland (Town, county, and state)
10. Usual occupation: Home Life
11. Industry or business: At Home

FATHER
12. Name: Edward A. Dishroon
13. Birthplace: Quantico Md.

MOTHER
14. Maiden name: Olivia F. Hearn
15. Birthplace: Quantico Md.

16. Informant: Mr. Randolph A. Holloway
Address: R.D. # 2. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 30-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & C. Walter R. Holloway
Salisbury Maryland.

19. 6/28/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th 1947, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10th 1947 to June 26 1947 and that I last saw h... alive on June 26 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to:

Due to:

Other conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE William Emrick M. D. or other
Address Helen Md. Date signed June 28-47

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

05427

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Mt Vernon, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sadie E. Horner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife John W. Horner
6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) April 11, 1898

8. AGE: Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace Tyaskin, Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name George Timmons
13. Birthplace Tyaskin, Md.

MOTHER
14. Maiden name Alice Hayward
15. Birthplace Tyaskin Md.

16. Informant Mrs Wade Bloodsworth Jr.
Address Princess Anne Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21 1947 (month) (day) (year)
Cemetery or crematory Asbury Cemetery
Location Mt Vernon Md
18. Funeral director Dale Dashiell
Address Princess Anne Md.

19. 6/20 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19
and that ~~Plast saw h~~ alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Lankford M.D.
Address Princess Anne Md M. D. or other
Date signed 6/19/47

HENRY M. LANKFORD, M.D.
Deputy Medical Examiner
Somerset County

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

05428

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Cordella Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Noah Hudson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Sadie Hudson
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov. 21 1875

8. AGE: Years: 71 | Months: 7 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Giddletree Worcester Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: James Hudson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Elay E. Timmons
Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25 47 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Giddletree, Md

18. Funeral director: Elay E. Timmons
Address: Snow Hill, Md

19. 6/24 1947 (Date rec'd by registrar) T. Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/23/47 19 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/19/47 19 to 6/23/47 19 and that I last saw him alive on 6/22/47 19

Immediate cause of death	DURATION
Diabetes Mellitus	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Owen M.D.
M. D. or other
Address: Snow Hill Md Date signed: 6/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Gromse

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55e

CERTIFICATE OF DEATH

05429

Reg. Diat. No. 993

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 nights.

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 4 nights.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Pittsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jackson, Miss Agnes M.

3.(b) Social Security Number 714-10-7076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) July 5, 1892.

8. AGE: Years 54 | Months 11 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace Pasadena, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Secretary

11. Industry or business Investments

FATHER
12. Name Wm. J. Jackson
13. Birthplace Wyoming Co. Pa.

MOTHER
14. Maiden name Gertrude Parker
15. Birthplace Wyoming Co. Pa.

16. Informant J. Walter Jackson, Jr.
Address Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/16/47 (month) (day) (year)

Cemetery or crematory Melodies

Location Pasadena, Md.

18. Funeral director R. Tull Shaw Co.

Address Salisbury, Md.

19. 6/16, 1947. Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to 6/14 1947 and that I last saw her alive on 6/14/47 19...

Immediate cause of death	DURATION
Carcinoma - metastatic	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE L. K. James M.D.
M. D. or other

Address Salisbury, Md. Date signed 6/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

163G 05430

Reg. Dist. No. 333

VS A15 1 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ✓
Hospital, institution, or street address where death occurred: P.H. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Patterson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ethel Belle Jenkins

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: George T. Jenkins
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): June 12-1882
8. AGE: Years: 64 69 | Months: 11 | Days: 20 | If less than one day: hr. min.
9. Birthplace: Tyaskin Md. (Town, county, and state)
10. Usual occupation: operator at
11. Industry or business: Shirt Factory

FATHER
12. Name: Edmund T. Messick
13. Birthplace: Tyaskin Md

MOTHER
14. Maiden name: Fowler Emily
15. Birthplace: Byrdale Md.

16. Informant: Mr. Isaac J. Messick
Address: Salisbury Fire Dept. #1. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Wilson & Co. Walter R. Wilson
Address: Salisbury Maryland

19. 6/4/47 (Date rec'd by Registrar) 19 H.L. Harriet L. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2nd 1947 at 2.9. A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Poisoning	2 hrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 6-1-47
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Took poison Injured at work? No

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury Md Date signed 6/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

05431

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Jesterville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jones-James

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Mary Delia Jones
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1886

8. AGE: Years	Months	Days	If less than one day
60	5	14	hrs. min.

9. Birthplace: Dames Quarter, Md. Somerset Co.
(Town, county, and state)
10. Usual occupation: oysterman
11. Industry or business

FATHER
12. Name: William White
13. Birthplace: Dames Quarter, Md.

MOTHER
14. Maiden name: White Brown
15. Birthplace: " "

16. Informant: Vance Jones
Address: Jesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/10/47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Jesterville Col. Cemetery

18. Funeral director: C. G. Messick
Address: Bivalve, Md.

19. 6/9 1947 Received by Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6- 1947 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-6 1947, to 6-6 1947
aed that I last saw h alive on 6-6- 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William H. Fobes Jr. M. D. or other
Address: Salisbury Md Date signed: 6-6-47

VS A15 5-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05432

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LOLA SMITH LONG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Guy E. Long

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): October 18, ~~1945~~ 1886

8. AGE: Years	Months	Days	If less than one day
60	7	19	hrs. min.

9. Birthplace: Salisbury, Wicomico, Maryland (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Fred L. Smith

FATHER — 13. Birthplace: Salisbury, Wicomico, Maryland

MOTHER — 14. Maiden name: Josephine Carprew

MOTHER — 15. Birthplace: Baltimore, Maryland

16. Informant: Carroll G. Long

Address: Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/10/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Maryland

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland

19. 6/10/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1947, 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1946, to 6/7 1947

and that I last saw h[illegible] alive on 6/7/47 19

Immediate cause of death — DURATION

Coronary Occlusion

Due to: Chr. Myocarditis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Fred A. Grana M.D. M. D. or other

Address: Salisbury, Md. Date signed: 6/7/47

Dr. Starr

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

05433

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Shaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lowe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			9 hrs. 25 min.

9. Birthplace Salisbury, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Lowe Eugene Leroy

13. Birthplace Shaptown, Maryland

MOTHER 14. Maiden name Fletcher Norma Janie

15. Birthplace Shaptown, Maryland

16. Informant

Address

17. Cremation Date thereof 6-14-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory [illegible]

Location Salis., Md.

18. Funeral director Peninsula General Hospital

Address Salisbury Maryland

19. 6/16/47 Carrie L. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1947 to June 13 1947 and that I last saw h[illegible] alive on June 13 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to Prematurity (6 mo)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert B. Starr M. D. or other

Address Salisbury Date signed 6-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05434

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Delaware
City or town: Darby
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 536 Blockade Ave. Yeadon
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert John Maines Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
M.	W.	Married

6.(b) Name of husband or wife: Ida Fennimore Maines

6.(c) If single, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 7, 1923

8. AGE: Years: 24 Months: 5 Days: 9 If less than one day: ..... hrs. ..... min.

9. Birthplace: Philadelphia Pa.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Building Materials

FATHER — 12. Name: Robert James Haines
FATHER — 13. Birthplace: Belfast Ireland

MOTHER — 14. Maiden name: Florence M. Maines

MOTHER — 15. Birthplace: New York City

16. Informant: R. J. Maines Jr.
Address: Darby Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/19/47 (month) (day) (year)
Cemetery or crematory: Glen Olden
Location: Pa.

18. Funeral director: Daniel L. Messick
Address: Hebron Md.

19. 6/16 19 47 Received by: C. E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw him ..... alive on ..... 19 .....

Immediate cause of death: paroxysmal Tachycardia
paroxysmal tachycardia — DURATION: 6 weeks

Due to: Liver necrosis — 6 weeks

Due to: .....

Other conditions: .....
(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: for Roclempher MD
Deputy Med. Examiner
M. D. or other

Address: Salisbury Md. Date signed: 6/16/47

5462

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: William R. Marshall

3.(b) Social Security Number: none

4. Sex: Male
5. Color or Race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Bertie M. Marshall
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan. 18 - 1889
8. AGE: Years: 58 Months: 5 Days: 6 If less than one day: ..... hrs. ..... min.
9. Birthplace: Tangier, Virginia (Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business:
FATHER 12. Name: William Marshall
13. Birthplace: Virginia
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Mrs Bertie M. Marshall
Address: Pittsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27/47 (month) (day) (year)
Cemetery or crematory: Grace Methodist
Location: Pittsville, Md
18. Funeral director: Olay E. Pippin
Address: Snow Hill, Md
19. 6/26/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 19 47, at 11 53 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August, 1945 19 ..... to day of death 19 ..... and that I last saw him alive on 6-24-47 19 .....

Immediate cause of death	DURATION
Coronary occlusion thrombosis	1 hour
Due to	
Due to	
Other conditions: Had had previous attacks of partial coronary occlusion. (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank R Lewis M.D. M. D. or other
Address: Willards Md. Date signed 6-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Diat. No. 05430 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #4 (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elisha Parker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Priscilla Ellen Parker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1863

8. AGE: Years: 84 Months: 4 Days: 24 If less than one day: hrs. min.

9. Birthplace: Wicomico Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Sampson Parker

FATHER — 13. Birthplace: Wicomico Co. Maryland

MOTHER — 14. Maiden name: Elizabeth Hannah Parsons

MOTHER — 15. Birthplace: Wicomico Co. Maryland

16. Informant: Geo. J. Parker

Address: Salisbury, Maryland - R.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Maryland

18. Funeral director: H. M. Tull & Johnson Co.

Address: Salisbury, Maryland

19. 6/12/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 19 47, at 10 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 6/9 1947 and that I last saw h alive on 6/9/47. 19

Immediate cause of death	DURATION
Myocarditis, Chronic	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. L. Cramer M.D. M. D. or other

Address: Salisbury, Md. Date signed 6/9/47

VS. A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

05437

CERTIFICATE OF DEATH

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, institution, or street address where death occurred: 801 Poplar Hill Ave
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 Poplar Hill Ave.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3.(a) FULL NAME Parsons, Ella Cattell

3.(b) Social Security Number ✓

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: E. J. C. Parsons
6.(c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.): Sept. 11, 1868.

8. AGE: Years 78 Months 9 Days 10 If less than one day ... hrs. ... min.

9. Birthplace: Wicomico Co. Md
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business ✓

FATHER
12. Name: Thomas Ennis
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Henrietta Mills
15. Birthplace: Wicomico Co. Md

16. Informant: Mrs. Lea M. Payne
Address: 801 Poplar Hill Ave., Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?)
Date thereof: 6/23/47 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.

18. Funeral director: Lee Hill & Johnson Co.
Address: Salisbury, Md.

19. 6/23, 1947 Harriet E. Johnson, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1947, at 2-4 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h... alive on ... 19 ...
medical examiner's report

Immediate cause of death: Chronic Cardiovascular & renal disease.
DURATION: 7 yrs

Due to ...

Due to ...

Other conditions ...
(Include pregnancy within 3 months of death)

Major findings of operations: None
None Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: J. A. Rademaker M.D. Deputy Med Examiner
M. D. or other
Address: Salisbury, Md Date signed: 6/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05425

Reg. Dist. No. 335

1. PLACE OF DEATH:
County: Kiamonica
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wic.
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: J. Hilber Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	

6.(b) Name of husband or wife: Dorothy Phillips
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): March 16 1874

8. AGE: Years	Months	Days	If less than one day
72	4		hrs. min.

9. Birthplace: Sussex Del
(Town, county and state)
10. Usual occupation: Marine Engineer
11. Industry or business:

FATHER
12. Name: Joseph H. Phillips
13. Birthplace: Del.

MOTHER
14. Maiden name: Victora Cooper
15. Birthplace: Del

18. Informant: John Phillips
Address: Sharptown

17. (Burial, ~~cremation, or removal~~? Which?) Burial Date thereof 6 19 1947 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown
18. Funeral director: Graham or Bros
Address: Sharptown Md.

19. (Date rec'd by registrar) June 18 1947 Walter H. Mann, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/16 1947 at 1-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947, to June 16 1947, and that I last saw h alive on June 16 1947.

Immediate cause of death	DURATION
Coronary Occlusion	5 hrs.
Due to: Mitral Valvular disease	6 Month
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other
Address: Sharptown Md Date signed 6/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Stars

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

05438

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Delaware St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ruden, Janice Marilyn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	c	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1947 4:46 a.m.

8. AGE: Years | Months | Days | If less than one day: 16 hrs. 46 min.

9. Birthplace Salisbury Maryland (town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Ruden James Rogers

13. Birthplace Statesville N.C.

MOTHER 14. Maiden name Lowe Mary Jane

15. Birthplace Philadelphia Pa.

16. Informant

Address

17. (Burial, cremation, or removal. Which?) ✓ Date thereof June 25 1947 (month) (day) (year)

Cemetery or crematory P. M. L.

Location Salisbury Md.

18. Funeral director Peninsula General Hospital

Address Salisbury Maryland

19. 6/25 1947 Isaac C. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at 8 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1947 to June 24 1947 and that I last saw h.e.r. alive on June 24 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to Toxemia of pregnancy	
Due to Premature separation of placenta	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results Essen. Neg.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

22a SIGNATURE Robert R. Stars M. D. Other

Address Salisbury Date signed June 25 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

05439

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred:
John B. Parsons Home

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. John B. Parsons Home
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LONIA B. SHOCKLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: J.J.William Shockley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	15	hrs. min.

9. Birthplace: Worcester Co., Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Josiah Morris
13. Birthplace: Worcester Co., Maryland

MOTHER
14. Maiden name: Drucilla Godfrey
15. Birthplace: Worcester Co., Maryland

18. Informant: John B. Parsons Home
Address: Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/5/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland

19. 6/4 (Date rec'd by registrar) 19 47 Carrie G. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3, 19 47, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on ..... 19.....

Immediate cause of death	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: ..... M. D. or other

Address: ..... Date signed .....

05440

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 6 Months
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 903 North Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MAGDELENE M. SPANG

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: J. L. Spang
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): September 6, 1896

8. AGE: Years	Months	Days	If less than one day
50	9	21	..... hrs. ..... min.

9. Birthplace: Franklin, Indiana
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:

FATHER
12. Name: Joseph Schmith
13. Birthplace: Indiana

MOTHER
14. Maiden name: Mary Boles
15. Birthplace: Indiana

16. Informant: J.L. Spang
Address: 905 N. Division St., Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/1/47 (month) (day) (year)
Cemetery or crematory: Holyhood
Location: Brookline, Mass.
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Maryland

19. 6/28/47 (Date rec'd by registrar) 19.. H. L. Massey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 19 47, at 1:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 47, to June 27 19 47
and that I last saw h[illegible]live on June 26 19 47

Immediate cause of death	DURATION
Carcinoma of Liver	Unknown
Due to	
Due to	
Other conditions: Amputation Breast for carcinoma in 1944 (Include pregnancy within 3 months of death)	4 yrs

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: Salisbury Md Date signed 6/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05441

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, R.D. 1 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 years

Hospital, institution, or street address where death occurred: Salisbury, Md. R.D. 1

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. 1 (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Hillian James Dorsey

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Jane Dorsey 6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): July 22, 1874.

8. AGE: Years 72 | Months 11 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace: Wicomico Co., Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ✓

FATHER — 12. Name: Elijah Dorsey

FATHER — 13. Birthplace: Wicomico Co., Md.

MOTHER — 14. Maiden name: Emma Hillians

MOTHER — 15. Birthplace: Wicomico Co., Md.

16. Informant: Mrs. Hillian H. Dorsey

Address: 110 Upton St., Salisbury, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6/17/47 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Head Lawn, Md.

18. Funeral director: De Vilbiss Brown Co.

Address: Salisbury, Md.

19. 6/17 1947 (Date rec'd by registrar) Carrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14, 1947, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1947, to 6/14 1947

and that I last saw him alive on 6/14 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Arteriosclerosis.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. R. Gramse M.D. (M. D. or other)

Address: Salisbury, Md. Date signed: 6/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05442

159

AB

Reg. Diat. No. 933

M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. #3

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Full-

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): June 25-1947

6.(c) If alive, give age: years

8. AGE: Years | Months | Days | If less than one day: 4 hrs. min.

9. Birthplace: Salisbury, Maryland. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Full, James Monroe

13. Birthplace: Sussex Delaware

MOTHER — 14. Maiden name: Hastings Julia Josephine

15. Birthplace: Sussex, Delaware

16. Informant

Address

17. (Burial, cremation, or removal. Which?) ✓ Date thereof: June 26-1947 (month) (day) (year)

Cemetery or crematory: Peninsula General Hospital

Location: Salisbury Md.

18. Funeral director: Peninsula General Hospital

Address: Salisbury maryland

19. 6/26/1947 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26- 1947 at 12 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 26 1947 and that I last saw h- alive on June 26 1947

Immediate cause of death	DURATION
Pneumonia (6 mos)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hiram R Mann M. D. or other

Address: Salisbury Md Date signed: 6/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05443

Reg. Dist. No. 337.

1

1. PLACE OF DEATH:
County Wicomico
City or town Pyanken R.F.D. No 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Pyanken Md R.F.D. No 1
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION) no
2.(a) If veteran, name war

3. (a) FULL NAME Wainwright, Frank

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife Mary Wainwright
Dead 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) about 1869

8. AGE: Years	Months	Days	If less than one day
about 78	—	—	...hrs. ...min.

9. Birthplace White Haven (Town, county, and state)
10. Usual occupation no
11. Industry or business no
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Ethel Peters
Address Pyanken
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7. 1947 (month) (day) (year)
Cemetery or crematory White Haven
Location White Haven
18. Funeral director James A. Stewart
Address Salisbury md
19. June 7 1947 (Date rec'd by registrar) R. Wolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Coronary Thrombosis	sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. A. Rademaker MD
Deputy Med Exmr. Wicomico
M. D. or other
Address Salisbury Md Date signed 6/2/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C.H.O.

COPY SENT TO ~~LOCAL REGISTRAR~~ No. ____ DATE 6-10-47

05444

83a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Pittsville, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Elizabeth White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: John B. White
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 11 - 1873

8. AGE: Years 74 | Months 3 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace: Pittsville Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: William F Parsons
13. Birthplace: Md

MOTHER — 14. Maiden name: Laura Freeney
15. Birthplace: Md

16. Informant: Carlis White
Address: Pittsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2 1947 (month) (day) (year)

Cemetery or crematory: Grace
Location: Pittsville Md

18. Funeral director: Wm Howard Wells
Address: Pittsville Md

19. 7/1 1947 Harriet E Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29th 1947, at 9-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940 to June 29 1947 death and that I last saw her alive on June 27 1947 1947

Immediate cause of death	DURATION
Repeated Cerebral Hemorrhages	
1st one in aug 1944 Last one day of death	
Due to: Hypertension	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Frank R Sims M.D. M. D. or other
Address: Salisbury Maryland Date signed 6-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05445

Reg. Dist. No. 3 33

1. PLACE OF DEATH:

County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: X

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD

(If rural, give LOCATION)

2.(a) If veteran, name war: X

3.(a) FULL NAME: ARTHUR GORMAN WILKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elberta Wilkins

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1906

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
41	3	27		

9. Birthplace: Willards, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: John Wilkins
13. Birthplace: Md.

MOTHER
14. Maiden name: Leona Hall
15. Birthplace: Md.

16. Informant: Mrs. Elberta Wilkins
Address: Willards, Md. RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27 1947 (month) (day) (year)
Cemetery or crematory: New Hope
Location: Willards Md.

18. Funeral director: M Pasha Watson
Address: Salisbury, Md.

19. 6/27/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 19 47 at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 45 to day of death and that I last saw him alive on 6-24-47 19

	DURATION
Immediate cause of death: Pulmonary tuberculosis	3 yrs ?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank R Lowe M.D. M. D. or other

Address: Willards Md. Date signed 6-25-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05436

Reg. Dist. No. 537

1. PLACE OF DEATH:
County Wicomico
City or town Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
No
How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town near White Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME James Franklin Wright.

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	married

6.(b) Name of husband or wife Nora Wright
6.(c) If alive, give age Don't know years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1882

8. AGE: Years	Months	Days	If less than one day
65	7		hrs. min.

9. Birthplace Salisbury Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation Farming
11. Industry or business Same as above
FATHER 12. Name Josiah Wright
13. Birthplace Salisbury Md.
MOTHER 14. Maiden name Adeline Wright
15. Birthplace Fruitland Md.
16. Informant Mrs. Rose Goldsborough
Address Baltimore, Md.
17. Burial Date thereof 6-15-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Community
Location near White Haven
18. Funeral director James F. Stewart
Address 402 E. Church St. Salisbury Md.
19. June 13 1947 R. Wolfe Walter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 June 1947, at 9 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 May 1947 to 12 June 1947 and that I last saw him alive on 12 June 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	1 weeks.
Due to Arterio sclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Leland H. Saunders M.D.
M. D. or other
Address Westside Md. Date signed 13 June 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M